FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040550

Facility Name: Courtyard Terrace Nursing Home

Address: 2313 Rocton Rd (Number) Rockford (City) 61103 (Zip Code)

County: Winnebago

Telephone Number: (815)964-2200 **Fax #** (815)965-7722

IDPA ID Number: 36-3985820

Date of Initial License for Current Owners: 1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Bob Kagda **Telephone Number:** (847)-675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Bob Kagda, Partner

(Firm Name & Address) Krupnick, Bokor, Kagda & Brooks, Ltd. 3750 W. Devon Ave. Lincolnwood, Il 60712-1124

(Telephone) (847)-675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	95	Skilled (SNF)	95	34,675	1
2		Skilled Pediatric (SNF/PED)			2
3	67	Intermediate (ICF)	67	24,455	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,130	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,629	1,629	8
9	SNF/PED					9
10	ICF	28,467	2,112		30,579	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,467	2,112	1,629	32,208	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.47%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 1,629

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	142,334	5,316	11,440	159,090		159,090		159,090			1
2	Food Purchase		176,537		176,537	(15,157)	161,380	(115)	161,265			2
3	Housekeeping	93,026	13,340		106,366		106,366		106,366			3
4	Laundry	38,355	10,102		48,457	(1,395)	47,062		47,062			4
5	Heat and Other Utilities			107,325	107,325		107,325	1,824	109,149			5
6	Maintenance	44,002		40,428	84,430		84,430	3,844	88,274			6
7	Other (specify):*											7
8	**TOTAL General Services**	317,717	205,295	159,193	682,205	(16,552)	665,653	5,553	671,206			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,002,399	39,024	1,920	1,043,343	1,395	1,044,738		1,044,738			10
10a	Therapy	43,481		23,585	67,066		67,066		67,066			10a
11	Activities	51,911	2,725		54,636		54,636		54,636			11
12	Social Services	50,468		1,327	51,795		51,795		51,795			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,148,259	41,749	36,432	1,226,440	1,395	1,227,835		1,227,835			16
	C. General Administration											
17	Administrative	76,870		206,856	283,726		283,726	(148,056)	135,670			17
18	Directors Fees											18
19	Professional Services			44,891	44,891		44,891	(10,456)	34,435			19
20	Dues, Fees, Subscriptions & Promotions			11,705	11,705		11,705	14	11,719			20
21	Clerical & General Office Expenses	57,185	38,367	131,958	227,510		227,510	(31,588)	195,922			21
22	Employee Benefits & Payroll Taxes			228,417	228,417	15,157	243,574	10,922	254,496			22
23	Inservice Training & Education											23
24	Travel and Seminar			888	888		888		888			24
25	Other Admin. Staff Transportation			3,575	3,575		3,575	956	4,531			25
26	Insurance-Prop.Liab.Malpractice			118,702	118,702		118,702	826	119,528			26
27	Other (specify):*											27
28	**TOTAL General Administration**	134,055	38,367	746,992	919,414	15,157	934,571	(177,382)	757,189			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,600,031	285,411	942,617	2,828,059		2,828,059	(171,829)	2,656,230			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Courtyard Terrace Nursing Home
0040550
COST REPORT RECLASSIFICATIONS
01/01/03
12/31/03

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	15,157	
2	FOOD		15,157

To reclass cost of employee meals from raw food to employee benefits

10	NURSING SUPPPLIES	1,395	
4	LAUNDRY SUPPLIES		1,395

To reclass diapers

Facility Name & ID Number Courtyard Terrace Nursing Home #0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			130,778	130,778		130,778	140,693	271,471			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			513,226	513,226		513,226	(21,755)	491,471			32
33	Real Estate Taxes			63,105	63,105		63,105	3,478	66,583			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							934	934			35
36	Other (specify):*											36
37	**TOTAL Ownership**			707,109	707,109		707,109	123,350	830,459			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,203	23,296	69,499		69,499		69,499			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,695	88,695		88,695		88,695			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		46,203	111,991	158,194		158,194		158,194			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,600,031	331,614	1,761,717	3,693,362		3,693,362	(48,479)	3,644,883			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	134,913	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(115)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(110)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,653)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(72,656)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(69,805)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (15,426)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(33,053)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (33,053)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (48,479)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Courtyard Terrace Nursing Home

ID# 0040550

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing	$ (4,187)	19	1
2	Trust Fees	(300)	19	2
3	Bank Charges	(37,304)	21	3
4	Penalties	(1,314)	21	4
5	Interest Paid to Owners	(26,700)	32	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(69,805)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(115)	0	0	0	0	0	0	0	0	0	0	(115)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,824	0	0	0	0	0	0	0	0	1,824	5
6	Maintenance	0	0	3,844	0	0	0	0	0	0	0	0	3,844	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(115)	0	5,668	0	0	0	0	0	0	0	0	5,553	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(148,056)	0	0	0	0	0	0	0	0	(148,056)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,140)	0	1,684	0	0	0	0	0	0	0	0	(10,456)	19
20	Fees, Subscriptions & Promotions	(110)	0	124	0	0	0	0	0	0	0	0	14	20
21	Clerical & General Office Expenses	(111,274)	0	79,686	0	0	0	0	0	0	0	0	(31,588)	21
22	Employee Benefits & Payroll Taxes	0	0	10,922	0	0	0	0	0	0	0	0	10,922	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	956	0	0	0	0	0	0	0	0	956	25
26	Insurance-Prop.Liab.Malpractice	0	0	826	0	0	0	0	0	0	0	0	826	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(123,524)	0	(53,858)	0	0	0	0	0	0	0	0	(177,382)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(123,639)	0	(48,190)	0	0	0	0	0	0	0	0	(171,829)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	134,913	0	5,780	0	0	0	0	0	0	0	0	140,693	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,700)	0	4,945	0	0	0	0	0	0	0	0	(21,755)	32
33	Real Estate Taxes	0	0	3,478	0	0	0	0	0	0	0	0	3,478	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	934	0	0	0	0	0	0	0	0	934	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	108,213	0	15,137	0	0	0	0	0	0	0	0	123,350	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(15,426)	0	(33,053)	0	0	0	0	0	0	0	0	(48,479)	45

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached				
				See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 206,856	Future Associates		$	$ (206,856)	15
16	V	5	Utilities		Future Associates		1,824	1,824	16
17	V	6	Maintenance		Future Associates		3,844	3,844	17
18	V	17	Administrative		Future Associates		58,800	58,800	18
19	V	19	Professional Fees		Future Associates		1,684	1,684	19
20	V	21	Clerical and General		Future Associates		79,686	79,686	20
21	V	22	Employee Benefits		Future Associates		10,922	10,922	21
22	V	25	Auto Expense		Future Associates		956	956	22
23	V	26	Insurance Expense		Future Associates		826	826	23
24	V	30	Depreciation		Future Associates		5,780	5,780	24
25	V	32	Interest Expense		Future Associates		4,945	4,945	25
26	V	33	Real Estate Taxes		Future Associates		3,478	3,478	26
27	V	35	Equipment Rental		Future Associates		934	934	27
28	V	20	License, Dues, Fees		Future Associates		124	124	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 206,856			$ 173,803	$ * (33,053)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Haim Perlstein	Administrator		17.42	117,600	30	0.50	Admin	$ 58,800	17-7	1
2	Nachshon Draiman	Director		53.66							2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 58,800		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Future Associates
Street Address: 7514 N. Skokie Blvd
City / State / Zip Code: Skokie, Il
Phone Number: (847)982-1195
Fax Number: (847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Management Fees	1,083,202	4	$ 9,550	$	206,856	$ 1,824	1
2	6	Maintenance	Management Fees	1,083,202	4	20,131		206,856	3,844	2
3	17	Administrative	Direct allocation			261,600			58,800	3
4	19	Professional Fees	Management Fees	1,083,202	4	8,817		206,856	1,684	4
5	21	Clerical and General	Management Fees	1,083,202	4	380,592	310,233	206,856	72,681	5
6	22	Employee Benefits	Management Fees	1,083,202	4	54,245		206,856	10,359	6
7	25	Auto Expense	Management Fees	1,083,202	4	5,005		206,856	956	7
8	26	Insurance Expense	Management Fees	1,083,202	4	4,326		206,856	826	8
9	30	Depreciation	Management Fees	1,083,202	4	30,268		206,856	5,780	9
10	32	Interest Expense	Management Fees	1,083,202	4	25,895		206,856	4,945	10
11	33	Real Estate Taxes	Management Fees	1,083,202	4	18,214		206,856	3,478	11
12	35	Equipment Rental	Management Fees	1,083,202	4	4,889		206,856	934	12
13	20	License, Dues, Fees	Management Fees	1,083,202	4	649		206,856	124	13
14	21	Clerical and General	Direct allocation			46,710	46,710		7,006	14
15	22	Employee Benefits	Direct allocation			3,753			563	15
16										16
17		Round off adj							(1)	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 874,644	$ 356,943		$ 173,803	25

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Yorkdale		X	Capital Lease	$43,800.00	11/01/94	$ 4,729,652	$ 4,735,698	8/01/19	10.0000	$ 474,543	1
2	Partners	X					460,000	460,000			26,700	2
3												3
4	Allocation from Future										4,945	4
5												5
	Working Capital											
6	Provider Fee		X								6,529	6
7	Insurance		X								5,445	7
8	IRS		X								9	8
9	TOTAL Facility Related				$43,800.00		$ 5,189,652	$ 5,195,698			$ 518,171	9
	B. Non-Facility Related*											
10	Adjust out Partners' Interest										(26,700)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (26,700)	14
15	TOTALS (line 9+line14)						$ 5,189,652	$ 5,195,698			$ 491,471	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$ 61,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 65,583	2
3. Under or (over) accrual (line 2 minus line 1).	$ 4,583	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 62,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 66,583	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	61,590	8
	1999	61,117	9
	2000	60,366	10
	2001	60,594	11
	2002	62,105	12
Rounded 2002 Tax Bill to		62,000	
Allocation From Future		3,478	

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Courtyard Terrace Nursing Home COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0040550

CONTACT PERSON REGARDING THIS REPORT Bob Kagda

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-11-354-001	Nursing Home	$ 62,105.00	$ 62,105.00
2.	10-28-408-025	Management Office	$ 17,915.80	$ 972.00
3.	10-28-408-026	Management Office	$ 8,751.07	$ 475.00
4.	10-28-408-027	Management Office	$ 8,751.07	$ 475.00
5.	10-28-408-028	Management Office	$ 12,701.72	$ 689.00
6.	10-28-408-029	Management Office	$ 12,701.72	$ 689.00
7.	10-28-408-030	Management Office	$ 1,522.14	$ 83.00
8.	10-28-408-031	Management Office	$ 1,522.14	$ 83.00
9.			$	$
10.			$	$
		TOTALS	$ 125,970.66	$ 65,571.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,171 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	39,171	11/1/1994	$ 160,000	1
2					2
3	TOTALS	39,171		$ 160,000	3

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	162		1994		$ 3,749,157	$ 96,133	20	$ 187,458	$ 91,325	$ 1,859,163	4
5	Alloc LCF			1986	41,505	1,743	30	1,384	(359)	23,635	5
6	Alloc LCF			1987	996	32	31.5	32		522	6
7											7
8											8
	Improvement Type**										
9	Various			1994	12,445	319	20	622	303	5,651	9
10	Various			1995	155,919	2,301	20	7,800	5,499	65,750	10
11	Various			1996	174,016	4,032	20	7,982	3,950	60,391	11
12	Various			1997	83,999	1,537	20	4,201	2,664	27,241	12
13	Various			1998	24,054	615	20	1,203	588	6,956	13
14	Various			1999	5,529	142	20	277	135	1,263	14
15	Control North Boiler			2/10/2000	644	17	20	64	47	252	15
16	Floor care			4/30/2000	2,000	51	20	100	49	375	16
17	New durarock wall			5/15/2000	4,540		20	227	227	832	17
18	Floor care			5/31/2000	1,026	26	20	51	25	188	18
19	Alarm system			7/7/2000	1,293	33	20	65	32	227	19
20	Clean condenser			7/19/2000	850	21	20	43	22	150	20
21	Starter on Elevator			10/5/2000	2,828	73	20	141	68	459	21
22	Weld patch heat Exch			11/20/2000	2,232	58	20	112	54	354	22
23	Compressor module			5/15/2001	1,354	35	20	68	33	181	23
24	Boiler igniter			6/4/2001	579	15	20	29	14	75	24
25	Storage tank			7/10/2001	6,950	178	20	348	170	869	25
26	Hot water pump			7/12/2001	1,026	27	20	51	24	128	26
27	Window A/C			8/1/2001	3,472	89	20	174	85	420	27
28	Compressor			8/9/2001	13,000	334	20	650	316	1,571	28
29	Ignition Control			10/3/2001	610	16	20	31	15	69	29
30	Alarm system			11/12/2001	2,580	67	20	129	62	280	30
31	Fire Alarm System			1/1/2002	1,589	41	20	79	38	119	31
32	Power Unit Hydraulic elevator			11/21/2002	8,475	217	20	424	207	636	32
33	Painting			12/2/2002	1,202	31	20	60	29	90	33
34	Painting			12/6/2002	1,642	42	20	82	40	123	34
35	Bolier work			12/11/2002	2,208	57	20	111	54	166	35
36	Heat Exchanger on Boiler			12/13/2002	6,500	167	20	325	158	488	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roof repairs	12/27/2002	$ 8,000	$ 205	20	$ 400	$ 195	$ 600	37
38	Inside double doors	1/1/2003	1,391	34	20	35	1	35	38
39	Paint, plastering	1/31/2003	1,638	40	20	41	1	41	39
40	Clean up	2/6/2003	5,430	122	20	136	14	136	40
41	Access control system	2/28/2003	1,766	40	20	44	4	44	41
42	Roof Repairs	3/19/2003	6,380	130	20	160	30	160	42
43	Exit door locking system	5/12/2003	1,270	20	20	32	12	32	43
44	Material	7/21/2003	723	9	20	18	9	18	44
45	Tree removal	10/27/2003	850	5	20	21	16	21	45
46	Fire alarm system	11/28/2003	880	3	20	22	19	22	46
47	Door closures	12/21/2003	755	1	20	19	18	19	47
48	Repair ceiling and painting 2nd floor	1/3/2003	2,045	50	20	51	1	51	48
49									49
50	Alloc from LCF	1987	5,712	181	31.5	181		2,646	50
51	Alloc from LCF	1988	321	10	31.5	10		156	51
52	Alloc from LCF	1989	119	4	31.5	4		54	52
53	Alloc from LCF	1993	3,318	85	39	85		882	53
54	Alloc from LCF	1994	5,059	130	39	130		1,226	54
55	Allocation from LCF-Air Cond; Roof repairs	2001	1,409	36	39	36		90	55
56	Allocation from LCF-5 Ton Trane A/C	2002	345	9	39	9		12	56
57	Allocation from LCF-Office Remodeling	2003	108						57
58	Alloc fro Future Associates	1987	18,002	571	31.5	581	10	9,806	58
59	Alloc fro Future Associates	1994	5,265	71	Var	319	248	3,158	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,385,006	$ 110,205		$ 216,657	$ 106,452	$ 2,077,833	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 502,665	$ 22,833	$ 51,359	$ 28,526	10	$ 399,235	71
72	Current Year Purchases	6,009	2,120	301	(1,819)	10	301	72
73	Fully Depreciated Assets	53,367	138	1,892	1,754	5	53,367	73
74								74
75	TOTALS	$ 562,041	$ 25,091	$ 53,552	$ 28,461		$ 452,903	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Alloc from Future			$ 36,852	$ 1,262	$ 1,262	$	5	$ 21,899	76
77										77
78										78
79										79
80	TOTALS			$ 36,852	$ 1,262	$ 1,262	$		$ 21,899	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,143,899	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 136,558	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 271,471	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 134,913	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,552,635	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	Operating Capital Lease			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Alloc from Future		$	$ 934	17
18					18
19					19
20					20
21	TOTAL		$	$ 934	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 1,316	$		$ 1,316	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			350			350	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			17,860			17,860	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				45,888		45,888	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					3,770	315		4,085	13
14	TOTAL			$		$ 23,296	$ 46,203		$ 69,499	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Endee LLC D/B/A Courtyard Terrace 0040550
1/1/2003 to ########

Special Services - Other (Col 6)	Reference	
Medical Supplies	39-2	315
Total		315

Special Services - Other (Col 5)		
Lab & Xray	39-3	3770
Total		3770

STATE OF ILLINOIS

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,515	$	1
2	Cash-Patient Deposits	122,150		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 53,600)	740,423		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	128,374		6
7	Other Prepaid Expenses	3,601		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(1,812)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 999,251	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	160,000		13
14	Buildings, at Historical Cost	3,749,157		14
15	Leasehold Improvements, at Historical Cost	442,284		15
16	Equipment, at Historical Cost	532,343		16
17	Accumulated Depreciation (book methods)	(1,522,558)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Exchange	4,302		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,365,528	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,364,779	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,545,503	$	26
27	Officer's Accounts Payable	5,265,554		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	460,000		29
30	Accrued Salaries Payable	44,730		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,399		31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,000		32
33	Accrued Interest Payable	39,464		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Schedule attached	217,000		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,671,650	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Schedule attached	4,735,698		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,735,698	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,407,348	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (8,042,569)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,364,779	$	48

***(See instructions.)**

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES As of 12/31/03

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	(1,812)	
Employee Advances		
	(1,812)	

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Lease Acquisition Costs	217,000	
	217,000	

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Loan Costs		

OTHER NON CURRENT LIABILITIES:		
Capitalized Lease Obligation	4,735,698	
	4,735,698	

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (7,456,687)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (7,456,687)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(585,881)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (585,881)	17
	B. Transfers (Itemize):		
18	**Round off Adj**	(1)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (8,042,569)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Nur	Courtyard Terrace Nursing Hom	#	0040550	Report Period Beginning:	01/01/03	Ending:	12/31/03

Balance per General Ledger		
Adjustments:		
		-
		-
		-
Round Off Adj		
Total adjustments		-
Balance - Beginning of Year		-
Equity(Deficit) from Page 17 Col 1		(8,042,569)
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		(8,042,569)

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,024,779	1
2	Discounts and Allowances for all Levels	(113,208)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,911,571	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	52,250	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 52,250	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	394	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	53,241	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,716	19
20	Radiology and X-Ray		20
21	Other Medical Services	(865)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 60,486	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Schedule attached	83,174	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 83,174	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,107,481	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	682,205	31
32	Health Care	1,226,440	32
33	General Administration	919,414	33
	B. Capital Expense		
34	Ownership	707,109	34
	C. Ancillary Expense		
35	Special Cost Centers	69,499	35
36	Provider Participation Fee	88,695	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,693,362	40
41	**Income before Income Taxes (line 30 minus line 40)****	(585,881)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (585,881)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not completed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **Courtyard Terrace Nursing Home** **# 0040550** **Report Period Beginning:** **01/01/03** **Ending:** **12/31/03**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/03

	DESCRIPTION		AMOUNT
1	Vending Commissions		
2	Adj of Prior period Expenses	Therapy	83,174
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
		TOTALS	83,174

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,026	3,237	$ 82,126	$ 25.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,859	4,022	82,283	20.46	3
4	Licensed Practical Nurses	15,478	16,303	303,230	18.60	4
5	Nurse Aides & Orderlies	56,141	57,501	534,760	9.30	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,442	5,908	43,481	7.36	8
9	Activity Director					9
10	Activity Assistants	5,881	6,262	51,911	8.29	10
11	Social Service Workers	3,259	3,684	50,468	13.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,674	21,404	142,334	6.65	15
16	Dishwashers					16
17	Maintenance Workers	3,949	4,251	44,002	10.35	17
18	Housekeepers	14,663	15,376	93,026	6.05	18
19	Laundry	6,739	6,948	38,355	5.52	19
20	Administrator	2,947	3,138	76,870	24.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,102	6,284	57,185	9.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	148,160	154,318	$ 1,600,031 *	$ 10.37	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 11,440		35
36	Medical Director	Monthly	9,600		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,920		39
40	Physical Therapy Consultant	424	22,225		40
41	Occupational Therapy Consultant	24	1,258		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	102		43
44	Activity Consultant				44
45	Social Service Consultant	26	1,327		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	475	$ 47,872		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
R Tipton	Admin		$ 24,234
Barbara Faron	Asst Admin		52,517
Accrual adjustments			119
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 76,870

B. Administrative - Other

Description	Amount
Future Associates	$ 206,856
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 206,856

C. Professional Services

Vendor/Payee	Type	Amount
Krupnick Bokor Kagda Brooks	Acctg	$ 4,900
L Cohn	Acctg	8,775
R Peelo	Med Acct	4,200
Personnel Planner	UC Consultant	3,469
Varios Data Processing Costs		10,580
	Marketing	4,187
Sachnoff & Weaver	Legal	5,606
Neal Gerber & Eisenberg	Legal	827
Sharon Rudy	Legal	1,365
	Legal	682
Trust Fees		300
Schedule attached		0
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 44,891

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,820
Unemployment Compensation Insurance	28,979
FICA Taxes	122,403
Employee Health Insurance	10,593
Employee Meals	15,157
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	1,402
Employee Education	277
Employee Uniforms	943
Alloaction from Future	10,922
TOTAL (agree to Schedule V, line 22, col.8)	$ 254,496

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,271
Health Care Worker Background Check	
(Indicate # of checks performed 36)	434
Dues and Sbscriptions	240
Licenses and Fees	5,650
Alloaction from Future	124
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,719

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	888
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 888

* Attach copy of IMRF notifications

**See instructions.

Page 21- Professional Services:

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Facility Name & ID Number Courtyard Terrace Nursing Home # 0040550 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$